Health Home Program
Washington

Health Home Program Consent Guidance Training

September 2021

Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority

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Purpose of this training

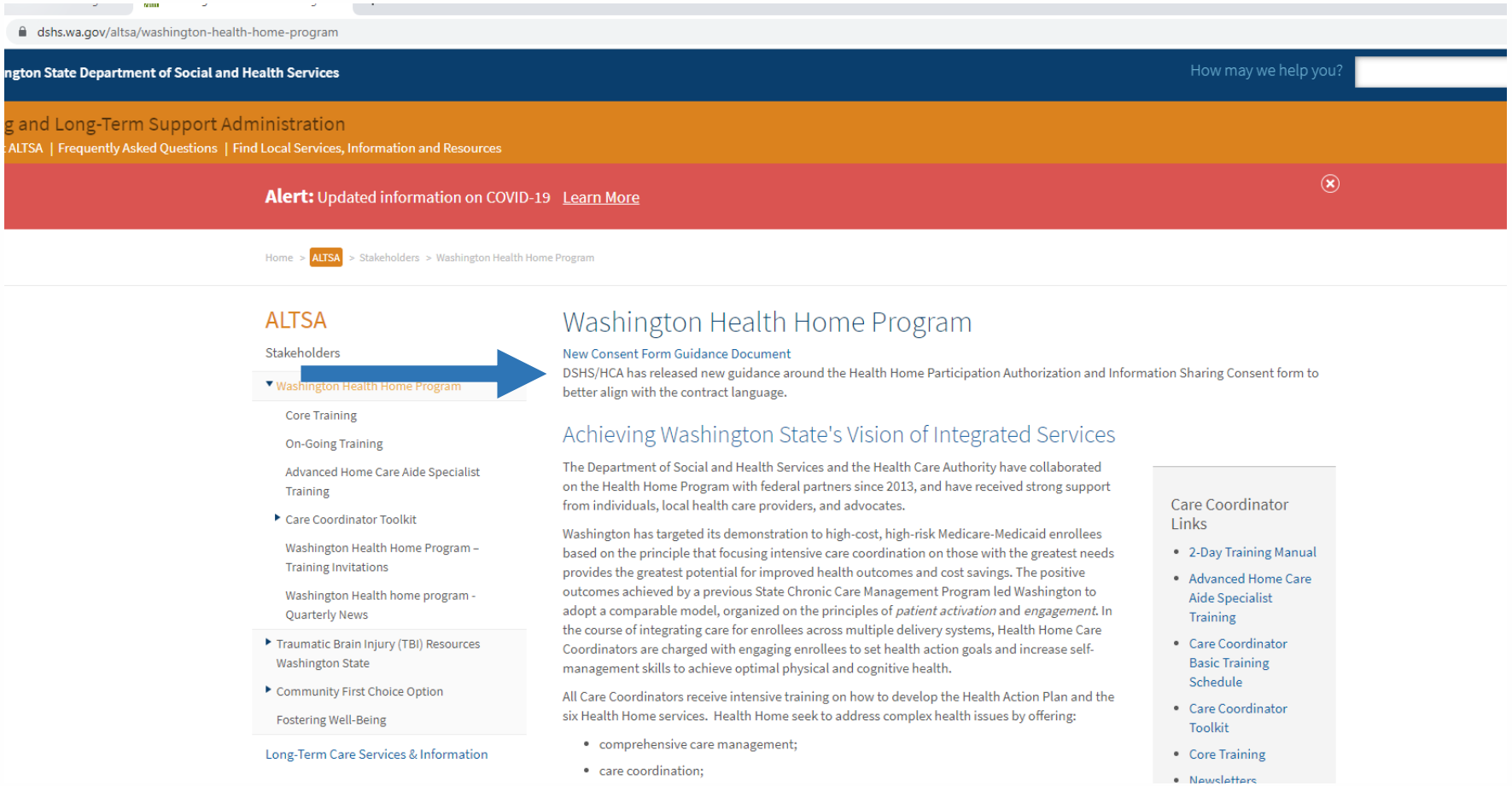
- Exhibit C Section 5.3 & 5.5 of the Health Home Contract states:

  Consent: Evidence of a completed (updated when applicable) and signed “Health Home Information Sharing Consent Form”

- This guidance will create a streamline process for completing the “Health Home Participation Authorization and Information Sharing Consent form”

Timeline

- **The Health Home team will start to score using this guide for TeaMonitor and FFS monitoring in 2023 for the 2022 reporting period**
  - FFS – July 2022 to June 2023
  - TeaMonitor – January 2022 to December 2022



https://www.dshs.wa.gov/altsa/washington-health-home-program

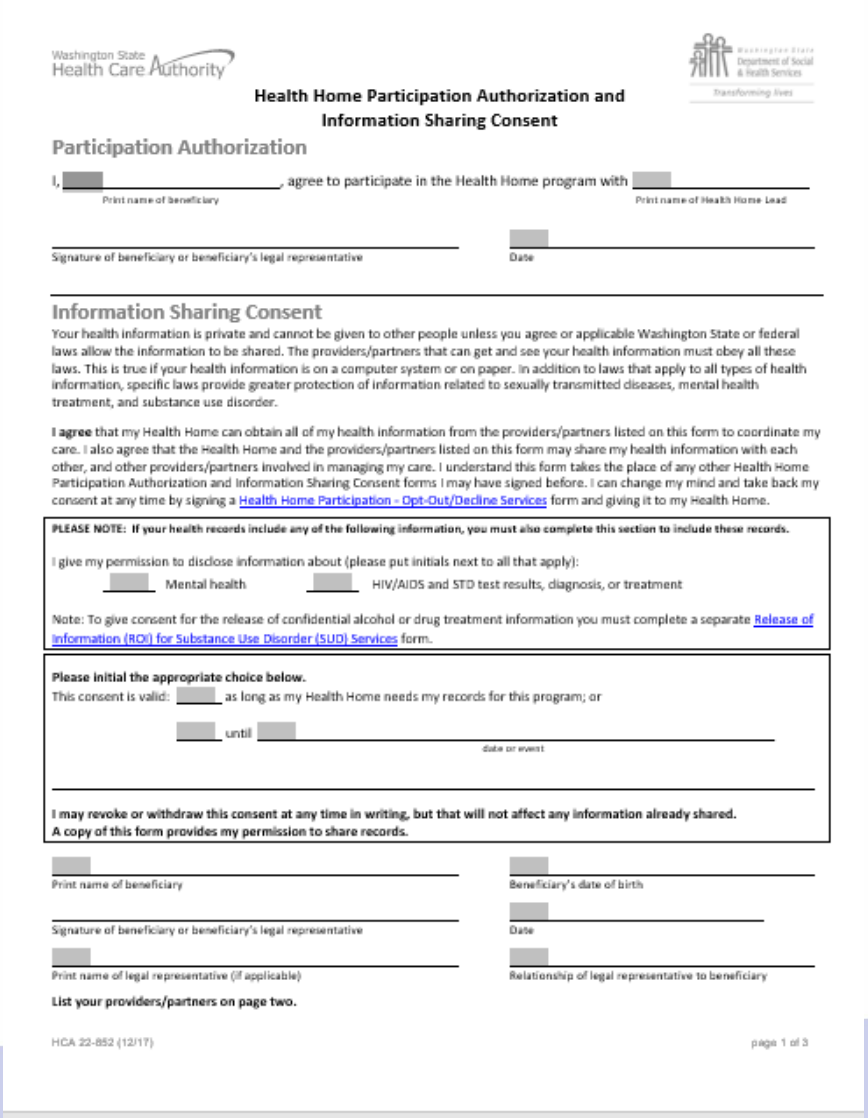
Health Home Consent	Guidance	How to complete the form
Purpose	• To create a streamline process for completing the Health Home participation authorization and information sharing consent.	• To be considered a valid consent the following must be completed. Pages 1 & 2 must be part of the beneficiary record
Page 1 – Health Home Participation Authorization		
	• Print name of beneficiary	• Beneficiary name must be printed clearly
	• Print name of Health Home lead	• Health Home lead name must be printed clearly
	• Signature of beneficiary or beneficiary's legal representative	• There must be a signature on this line
	• Date	• The full date must be clearly written

Providing verbal consent	• When it is not possible to get the beneficiary's signature prior to services, the Care Coordinator (CC) may explain or read the Health Home Participation Authorization form. The CC must clearly document the interaction	• Document in the beneficiaries file if they provided verbal consent or not.
		• Document name of person giving consent, the date consent was given and if there were any witnesses. Also document how the CC will follow up. For Example:
		  ○ Mailing a copy of the form with a return envelope for the beneficiary to sign, or
		  ○ Mailing a copy to the beneficiary.
		
		Note: Make sure to document on the form itself and in the notes.

Adolescent Beneficiary	• If the beneficiary is between the ages of 13-17 you must fill out the *Health Home Adolescent Information Sharing Consent form* (this is in addition to the Health Home Participation form)	• Complete the Health Home Adolescent Information Sharing Consent form

This document serves as a guide for documentation of Health Home Participation Authorization Information Sharing Consent. Please contact the Lead Organization for additional documentation requirements. Consult supervisor for documentation requirements established within the agency.

Page 1 Health Home Participation Authorization



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Health Home Participation Authorization and Information Sharing Consent

Participation Authorization

I, _____, agree to participate in the Health Home program with _____
Print name of beneficiary — Print name of Health Home Lead

_____ _____
Signature of beneficiary or beneficiary's legal representative — Date

Information Sharing Consent

Your health information is private and cannot be given to other people unless you agree or applicable Washington State or federal laws allow the information to be shared. The providers/partners that can get and see your health information must obey all these laws. This is true if your health information is on a computer system or on paper. In addition to laws that apply to all types of health information, specific laws provide greater protection of information related to sexually transmitted diseases, mental health treatment, and substance use disorder.

I agree that my Health Home can obtain all of my health information from the providers/partners listed on this form to coordinate my care. I also agree that the Health Home and the providers/partners listed on this form may share my health information with each other, and other providers/partners involved in managing my care. I understand this form takes the place of any other Health Home Participation Authorization and Information Sharing Consent forms I may have signed before. I can change my mind and take back my consent at any time by signing a Health Home Participation - Opt-Out/Decline Services form and giving it to my Health Home.

PLEASE NOTE: If your health records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose information about (please put initials next to all that apply):

_____ Mental health _____ HIV/AIDS and STD test results, diagnosis, or treatment

Note: To give consent for the release of confidential alcohol or drug treatment information you must complete a separate Release of Information (ROI) for Substance Use Disorder (SUD) Services form.

Please initial the appropriate choice below.

This consent is valid: _____ as long as my Health Home needs my records for this program; or

_____ until _____
date or event

I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
A copy of this form provides my permission to share records.

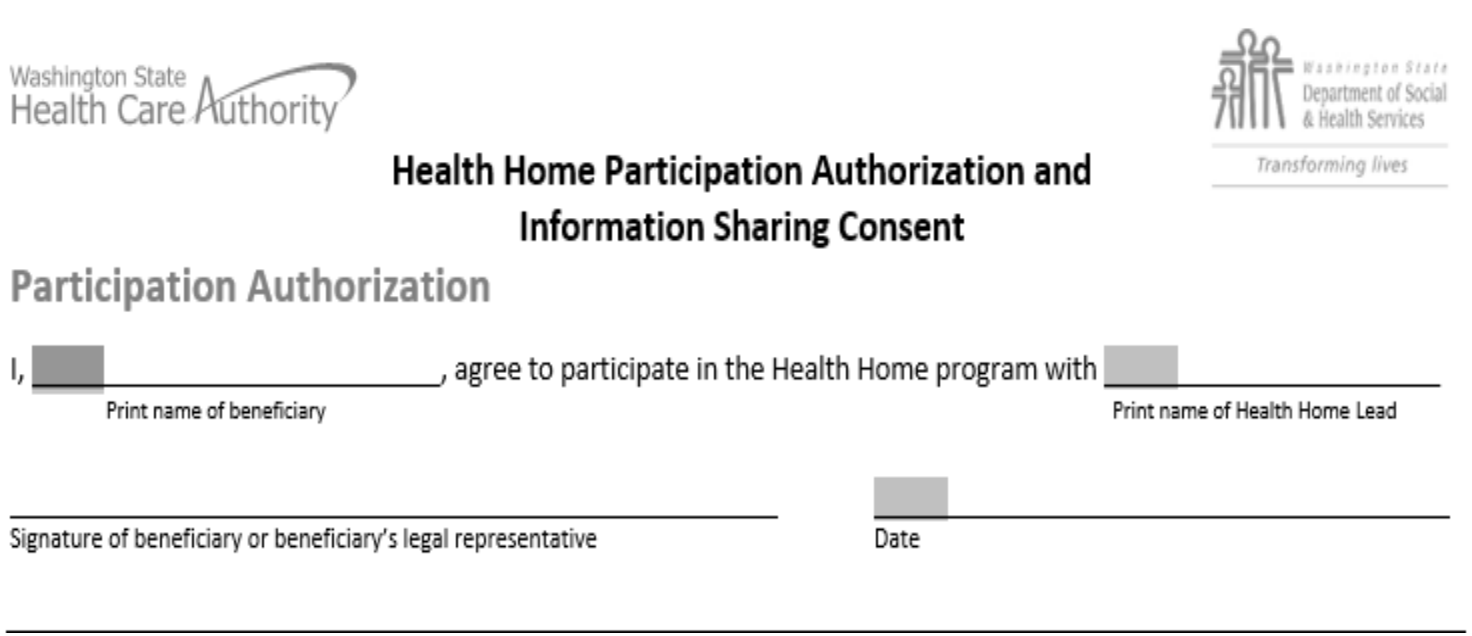
_____ _____
Print name of beneficiary — Beneficiary's date of birth

_____ _____
Signature of beneficiary or beneficiary's legal representative — Date

_____ _____
Print name of legal representative (if applicable) — Relationship of legal representative to beneficiary

List your providers/partners on page two.

HCA 22-852 (12/17) page 1 of 3



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Health Home Participation Authorization and Information Sharing Consent

Participation Authorization

I, _____, agree to participate in the Health Home program with _____

Print name of beneficiary — Print name of Health Home Lead

_____ _____

Signature of beneficiary or beneficiary's legal representative — Date

- Make sure that the beneficiary's name is printed clearly
- Make sure that the Health Home lead name is printed clearly
- There must be a signature of the beneficiary or the beneficiary's legal representative
- There must be a date on the form
- Make sure that it is the Lead entity is written, NOT the CCO under the name of the Health Home lead

Providing Verbal Consent for Participation Authorization

- Document in the beneficiary's file if they provided verbal approval or not
- Document name of person giving approval, the date approval was given with a return envelope for the beneficiary to sign, or
  - Mail a copy to the beneficiary

Note: Make sure to document on the form itself and in the notes

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Health Home Participation Authorization and Information Sharing Consent

Participation Authorization

I, Jane Doe, agree to participate in the Health Home program with Full Life Care

Print name of beneficiary — Print name of Health Home Lead

Verbal — 8.1.21

Signature of beneficiary or beneficiary's legal representative — Date

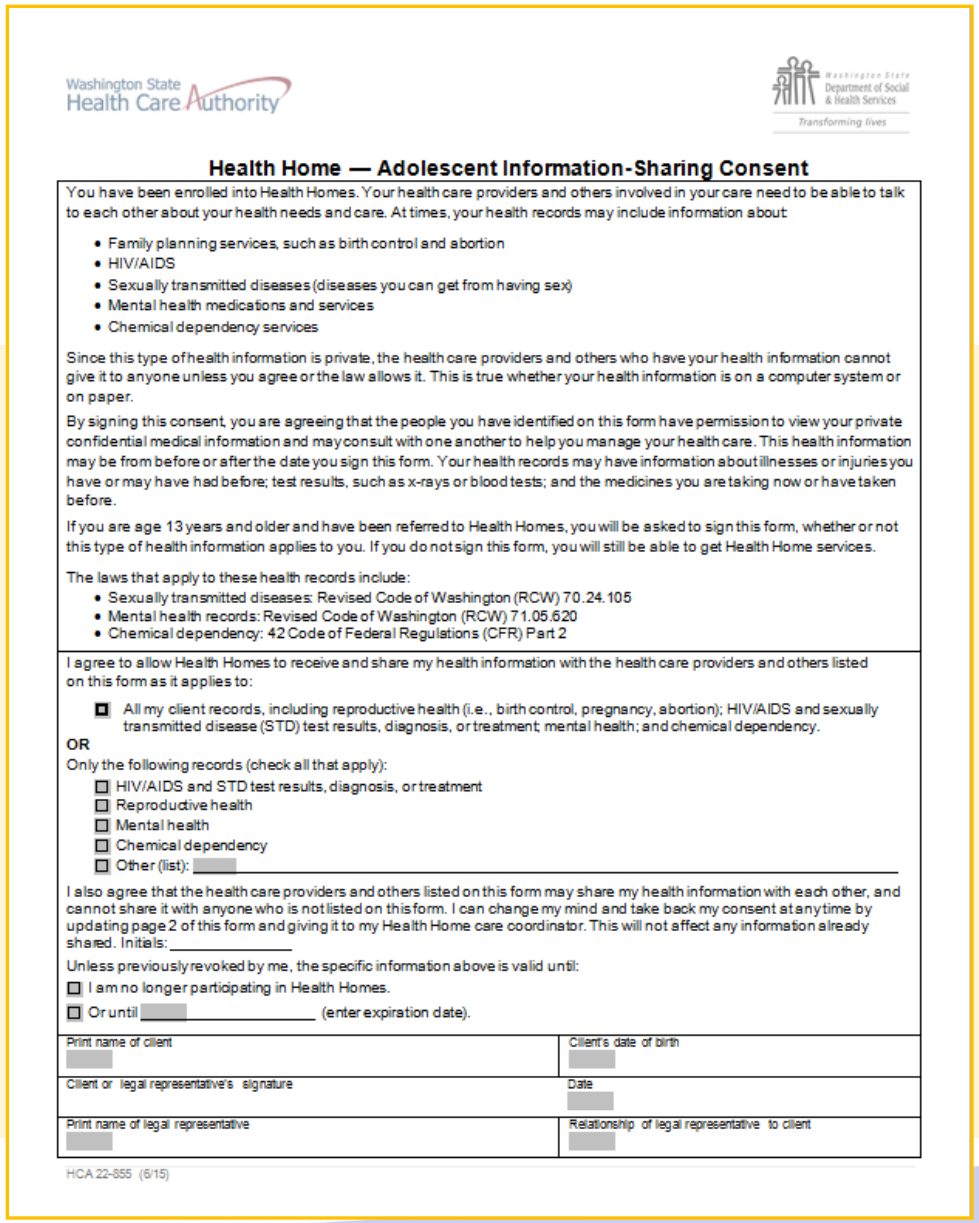
Information Sharing Consent

Adolescent Beneficiary Consent Form

For children 13–17 years of age

If the beneficiary is between the ages of 13-17 you must fill out the *Health Home Adolescent Information Sharing Consent form* (this is in addition to the Health Home Participation form)

Complete the Health Home Adolescent Information Sharing Consent form and include in beneficiary file



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Health Home — Adolescent Information-Sharing Consent

You have been enrolled into Health Homes. Your health care providers and others involved in your care need to be able to talk to each other about your health needs and care. At times, your health records may include information about:

- Family planning services, such as birth control and abortion
- HIV/AIDS
- Sexually transmitted diseases (diseases you can get from having sex)
- Mental health medications and services
- Chemical dependency services

Since this type of health information is private, the health care providers and others who have your health information cannot give it to anyone unless you agree or the law allows it. This is true whether your health information is on a computer system or on paper.

By signing this consent, you are agreeing that the people you have identified on this form have permission to view your private confidential medical information and may consult with one another to help you manage your health care. This health information may be from before or after the date you sign this form. Your health records may have information about illnesses or injuries you have or may have had before; test results, such as x-rays or blood tests; and the medicines you are taking now or have taken before.

If you are age 13 years and older and have been referred to Health Homes, you will be asked to sign this form, whether or not this type of health information applies to you. If you do not sign this form, you will still be able to get Health Home services.

The laws that apply to these health records include:

- Sexually transmitted diseases: Revised Code of Washington (RCW) 70.24.105
- Mental health records: Revised Code of Washington (RCW) 71.05.620
- Chemical dependency: 42 Code of Federal Regulations (CFR) Part 2

I agree to allow Health Homes to receive and share my health information with the health care providers and others listed on this form as it applies to:

☐ All my client records, including reproductive health (i.e., birth control, pregnancy, abortion); HIV/AIDS and sexually transmitted disease (STD) test results, diagnosis, or treatment; mental health; and chemical dependency.

OR

Only the following records (check all that apply):

☐ HIV/AIDS and STD test results, diagnosis, or treatment
☐ Reproductive health
☐ Mental health
☐ Chemical dependency
☐ Other (list): _____

I also agree that the health care providers and others listed on this form may share my health information with each other, and cannot share it with anyone who is not listed on this form. I can change my mind and take back my consent at anytime by updating page 2 of this form and giving it to my Health Home care coordinator. This will not affect any information already shared. Initials: _____

Unless previously revoked by me, the specific information above is valid until:

☐ I am no longer participating in Health Homes.
☐ Or until _____ (enter expiration date).

Print name of client	Client's date of birth
Client or legal representative's signature	Date
Print name of legal representative	Relationship of legal representative to client

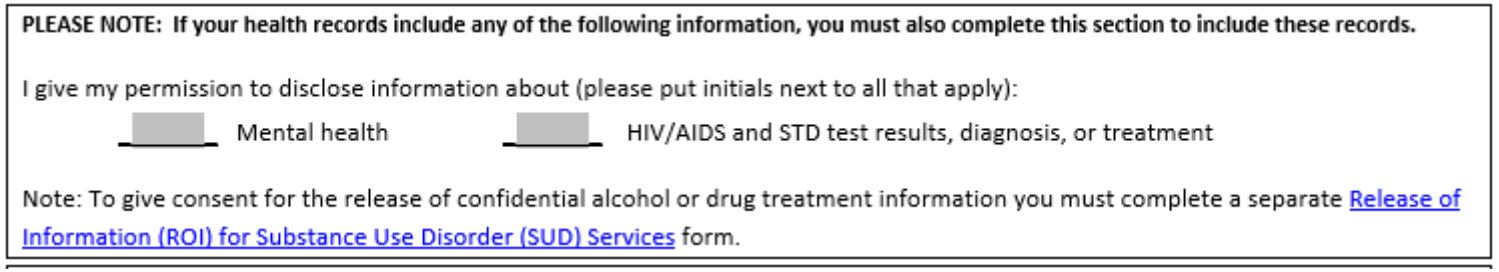
HCA 22-855 (6/15)

Optional disclosure for Mental Health, HIV/AIDS and STDs

For the consent to be valid when the beneficiary health records include any mental health, HIV/AIDS or STD information, this section must be complete

- **Initials must be next to the mental health field and/or the HIV/AIDS and STD results, diagnosis, or treatment field**

Note – a check mark or a line across the box is NOT considered a valid consent



PLEASE NOTE: If your health records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose information about (please put initials next to all that apply):

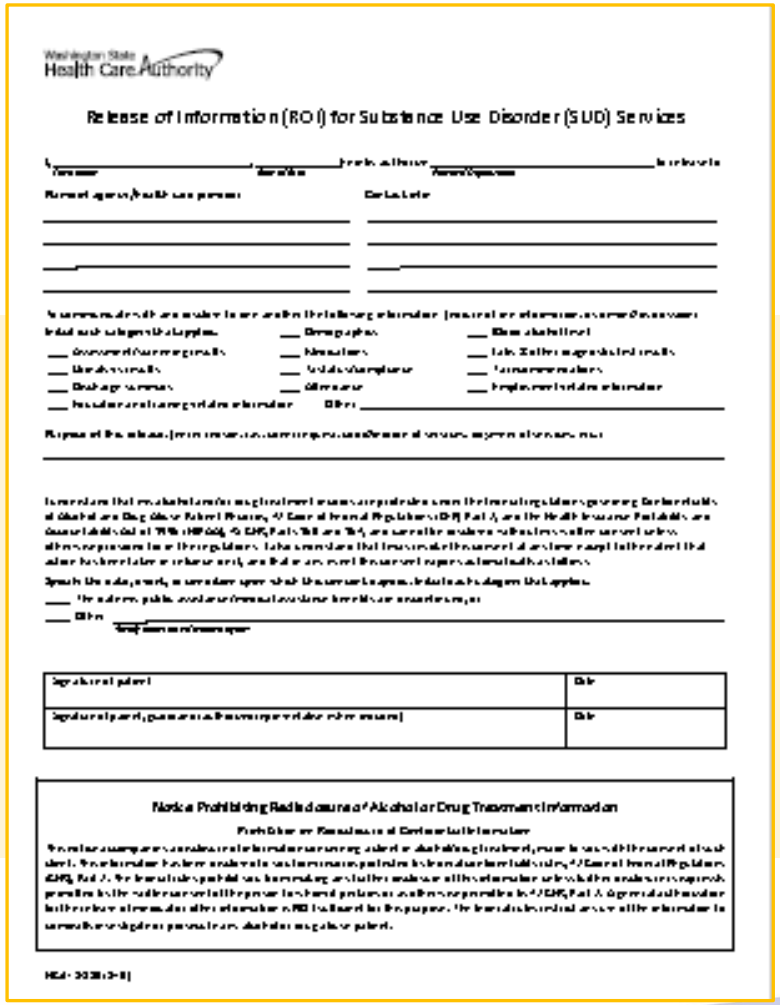
_____ Mental health _____ HIV/AIDS and STD test results, diagnosis, or treatment

Note: To give consent for the release of confidential alcohol or drug treatment information you must complete a separate Release of Information (ROI) for Substance Use Disorder (SUD) Services form.

Release of Information Form for Substance Use Disorders

If the client would like a release of information for the care coordinator to speak with the clients SUD treatment program regarding progress, UA's, etc there must be a separate release of information

This release of information is ONLY to speak with the SUD provider



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Release of Information (ROI) for Substance Use Disorder (SUD) Services

HCA form 13-335 (3/16)

Validity of Consent

- **Either initial “this consent is valid as long as the Health Home needs my records of the program” or initial “until” and print a clear full date (m/d/y)**
- **Note – a check mark or line across the box is NOT considered a valid consent**

Please initial the appropriate choice below.

This consent is valid: _____ as long as my Health Home needs my records for this program; or

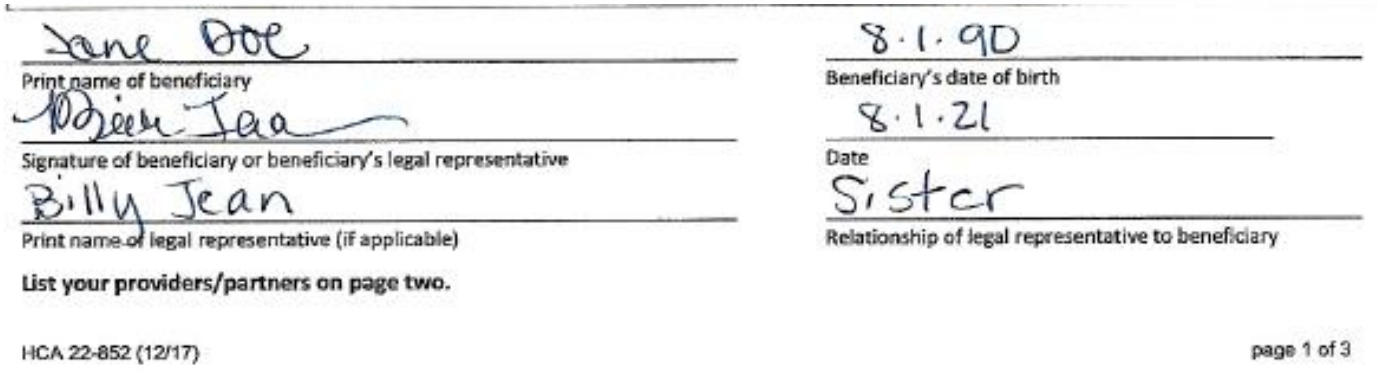
_____ until _____

date or event

I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
A copy of this form provides my permission to share records.

Beneficiary Signature

- **Beneficiary name must be visible and printed or typed in the document**
- **Print the beneficiary's full date of birth. Example: 08/01/1990, August 01, 1990 or 8/1/90**
- **Beneficiary or beneficiary's legal representative (if there is one) signs the information sharing consent portion of the form**



Jane Doe
Print name of beneficiary

8·1·90
Beneficiary's date of birth

Jane Doe
Signature of beneficiary or beneficiary's legal representative

8·1·21
Date

Billy Jean
Print name of legal representative (if applicable)

Sister
Relationship of legal representative to beneficiary

List your providers/partners on page two.

HCA 22-852 (12/17)

page 1 of 3

Providing Verbal Consent for the beneficiary or beneficiary's legal representative

When it is not possible to get the beneficiary’s signature prior to services, the Care Coordinator (CC) may explain or read the Health Home Participation Authorization form to beneficiary or their representative. The CC must clearly document the interaction

- **Document in the beneficiary’s file if they provided verbal consent**
- **Document name of person giving consent and date/time and if there were any witnesses and how the CC will follow up. For example; mailed the form with a return envelope for the beneficiary to sign, or mailed a copy to the beneficiary**

Note - Make sure to document on the form itself and in the notes

Page 2 of the form:

Print name of Health Home beneficiary: _____

List the name of participating providers/partners	Beneficiary Gives Consent		Beneficiary Withdraws Consent	
	Date	Initials	Date	Initials
Past Care Coordination Org. (CCO)/Lead				
Past CCO/Lead				

Release of Information

- **If there is a past lead or CCO make sure to clearly write in their name**
- **List any and all providers/people/facilities/tribal representatives in the following lines that the beneficiary would like to have the CC be able to share health information with**

- **Please note: if there is not a *full date or initials* of the beneficiary the release of information is NOT considered valid**

Release of Information

Do not write in generic provider categories such as ‘dental care provider’ or ‘primary care doctor.’ A specific provider name and/or specific treating clinic should be identified by the beneficiary

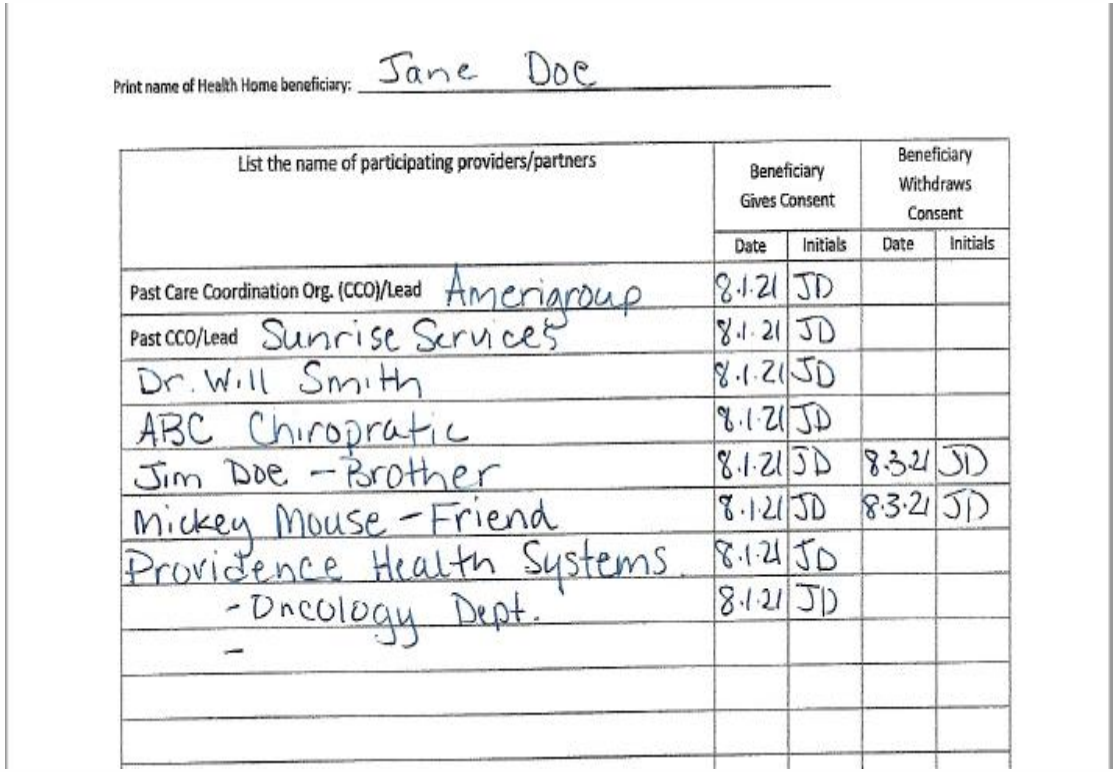
You may NOT use the following:

- Any Provider
- Any hospital
- No name at all
- Acronyms/abbreviations such as “CHI” or “MHS”
- “whoever needs information”

Adding or withdrawing consent for specific providers/partners

- **If the beneficiary chooses to add or withdrawal consent for providers they may do so by filling out the consent form. For adding a provider/partner use the "beneficiary gives consent" section of the form. If the beneficiary would like to withdrawal consent, they must fill out the "beneficiary withdrawals consent" columns on the consent form**

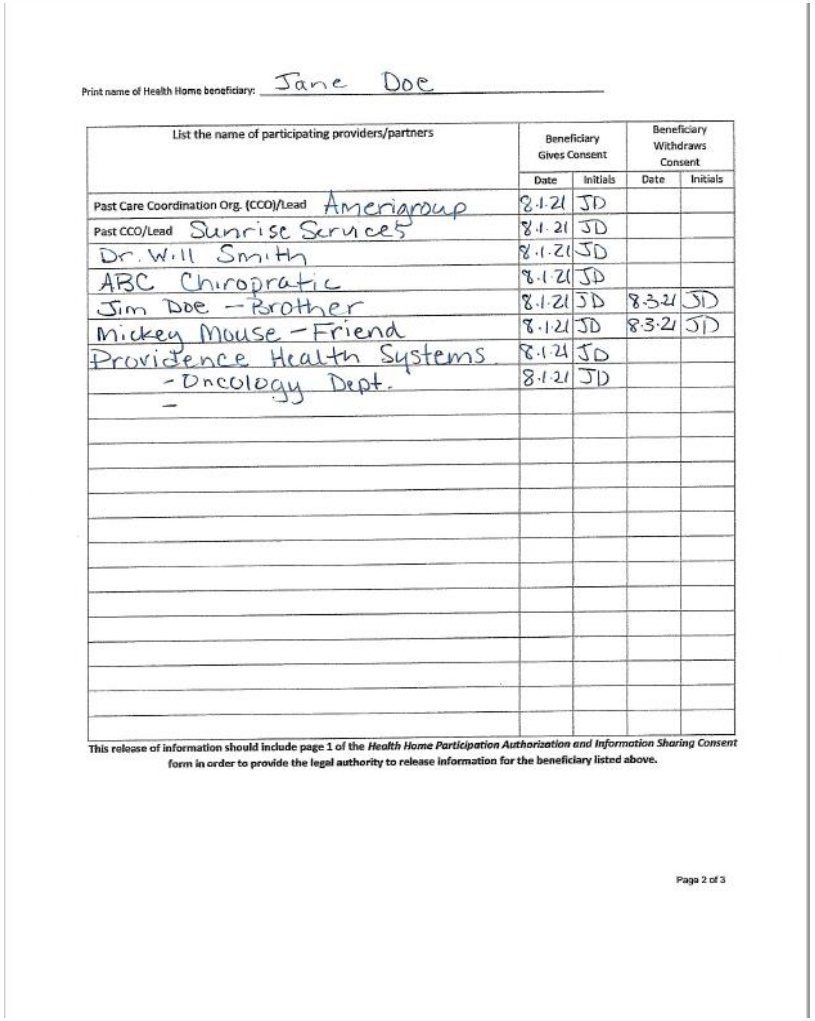
- **The beneficiary must also initial and date the consent for the addition or withdrawal to be considered valid**



Print name of Health Home beneficiary: Jane Doe

List the name of participating providers/partners	Beneficiary Gives Consent		Beneficiary Withdraws Consent	
	Date	Initials	Date	Initials
Past Care Coordination Org. (CCO)/Lead Amerigroup	8.1.21	JD		
Past CCO/Lead Sunrise Services	8.1.21	JD		
Dr. Will Smith	8.1.21	JD		
ABC Chiropratic	8.1.21	JD		
Jim Doe - Brother	8.1.21	JD	8.3.21	JD
Mickey Mouse - Friend	8.1.21	JD	8.3.21	JD
Providence Health Systems	8.1.21	JD		
- Oncology Dept.	8.1.21	JD		
-				

Correct



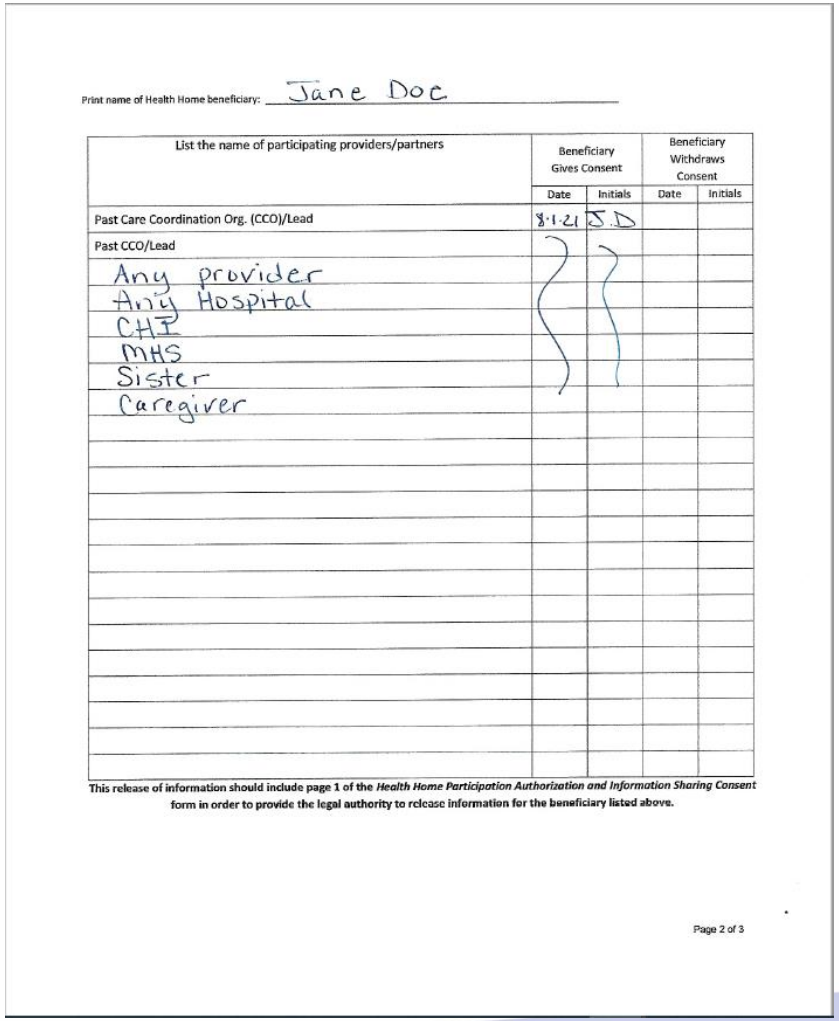
Print name of Health Home beneficiary: Jane Doe

List the name of participating providers/partners	Beneficiary Gives Consent		Beneficiary Withdraws Consent	
	Date	Initials	Date	Initials
Past Care Coordination Org. (CCO)/Lead Amerigroup	8.1.21	JD		
Past CCO/Lead Sunrise Services	8.1.21	JD		
Dr. Will Smith	8.1.21	JD		
ABC Chiropratic	8.1.21	JD		
Jim Doe - Brother	8.1.21	JD	8.3.21	JD
Mickey Mouse - Friend	8.1.21	JD	8.3.21	JD
Providence Health Systems	8.1.21	JD		
- Oncology Dept.	8.1.21	JD		
-				

This release of information should include page 1 of the *Health Home Participation Authorization and Information Sharing Consent* form in order to provide the legal authority to release information for the beneficiary listed above.

Page 2 of 3

Incorrect



Print name of Health Home beneficiary: Jane Doe

List the name of participating providers/partners	Beneficiary Gives Consent		Beneficiary Withdraws Consent	
	Date	Initials	Date	Initials
Past Care Coordination Org. (CCO)/Lead	8.1.21	J.D		
Past CCO/Lead				
Any provider				
Any Hospital				
CHI				
MHS				
Sister				
Caregiver				

This release of information should include page 1 of the *Health Home Participation Authorization and Information Sharing Consent* form in order to provide the legal authority to release information for the beneficiary listed above.

Page 2 of 3

Withdrawing participation in the Health Home Program

The beneficiary may withdrawal the Participation Authorization for Health Home at any time they chose. If available, the beneficiary will sign the Health Home Participation – Opt-Out/Decline Services form

- The beneficiary will sign and date the form if they are available to do so
- Best Practice - If the beneficiary declines, the Care Coordinator will complete on the beneficiary's behalf and make sure to include in the notes that the care coordinator filled out the form on the beneficiary's behalf

Beneficiary Information Sharing Consent Process

- **Explain to the beneficiary on how their information and share process will be used.**
  - Provide information that providers/partners will use the beneficiary's health information to coordinate and help the beneficiary's health care.
  - Please see page 3 of the consent form for details regarding beneficiary information sharing consent process

Reminders

- **On page 2, a line down the page after first initial or first date is NOT considered valid**
- **A check mark instead of initials is NOT considered valid**
- **If there is not a full date the release is NOT considered valid example**
- **Date must be filled out as follows:**
  - 01/01/2020
  - January 1, 2020
  - 01/01/20
  - 20210921
- **Beneficiary initials MUST be on each line that has an entity attached.**
- **The Health Home Participation Authorization must be filled out by the beneficiary to begin Health Home services but the Information Sharing Consent form is optional. Note, if the Information Sharing Consent form is not filled out the CC may not share information with any of the providers etc.**

New Guidelines on Annual Revisit of Release of Information

Beginning on January 1, 2022 the CC will be required to revisit the release of information annually with the client

- Make sure that ROI is up to date
- All entities are still current or adjust as needed
- Add or remove entities

Document in file that reviewed with client and if updates or changes was made

- Best practice is to take it to face-to-face visits and appointments to amend as needed

Questions????

Resources, Contacts & Questions

Health Home email box HealthHomes@hca.wa.gov

DSHS website: https://www.dshs.wa.gov/altsa/washington-health-home-program

HCA website: https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes

Washington State Health Care Authority

Health Home Program Washington

Transforming Lives

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